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Factors that contribute to the reluctance of mental health treatment seeking among African Americans

Natalie Nicole Majors-Stewart

FACTORS THAT CONTRIBUTE TO THE RELUCTANCE OF MENTAL HEALTH TREATMENT SEEKING AMONG AFRICAN AMERICANS

A Project

Presented to the

Faculty of

California State University,

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In Partial Fulfillment

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Master of Social Work

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by

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ABSTRACT

This study examined the factors that contribute to the reluctance of African Americans to seek mental health treatment. Data has shown that African Americans underutilize mental health treatment services, and according to the literature, there are major factors that contribute to this underutilization. Fifty-three African Americans were surveyed using a 40-item questionnaire. The most significant reluctance factors reported were a lack of sufficient financial resources, having a strong self-reliance, and a perceived lack of being understood by mental health professionals. Results also showed a gender difference in the reluctance among African American men and women. Future research is recommended to explore issues related to self-reliance and mental health treatment seeking among African Americans, and reluctance in the African American male population. Increased cultural competence and policy advocacy are recommended to ensure that practices are implemented to eliminate barriers to accessing mental health services.

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DEDICATION

I especially would like to express my deepest gratitude to my loving family who patiently stood by my side, and supported me throughout this entire educational journey. To my wonderful husband Lawrence, my magnificent parents Dennis and Billie, my amazing brother and sister-in-law, Matthew and Myiesha, and my fabulous sister Brittany...I love you all, with all of my heart!

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

The content of chapter one presents an overview of the project. The problem statement and purpose of the study are discussed. Finally, the significance of the project for social work is presented.

Problem Statement

As society changes and the demands of life become increasingly difficult, so does the need for individuals to maintain their mental health. The need for mental health services has grown, and timely treatment is very important to ensure that individuals stay mentally healthy (Mental Health Services Act, 2004). Despite this awareness of the importance mental health treatment, there are still underserved populations when it comes to mental health care. One such group is that of African Americans (U.S. Department of Health and Human Services, 2001).

The current problem that is being explored is the fact that African Americans are underrepresented in outpatient mental health treatment settings, but over represented in emergency mental health settings, such as emergency psychiatric hospitalizations (U.S. Department of Health and Human Services, 2001). Furthermore, many

African Americans are in high risk groups that are likely to need mental health support services, such as homelessness, prison, foster care, and victims of crime (U.S. Department of Health and Human Services, 2001). Additionally, African Americans have increased in their rates of serious mental illnesses, such as depression and suicide (NAMI Multicultural Action Center, 2004).

In looking at these statistics, it appears that, though African Americans are less likely to utilize preventative mental health treatment services, (Ward, 2005), they are nevertheless still experiencing major mental health disorders that need to be properly treated (U.S. Department of Health and Human Services, 2001). And though historically the mental health of African Americans was not an issue of concern for many professionals (Moffic, 2003), this issue of under service utilization is now finally starting to be recognized as a major social problem (Davis & Ford 2004).

As with social problems, there may be several layers to a single issue that can, and should be addressed from several different vantage points (Brueggemann, 2006, ch. 2). Within the context of social work practice, social problems can be addressed within the frameworks of the

major social work practice areas, which are micro practice, macro practice, and policy practice.

According to Mayo (2004), "the mental health service community responds to the African American psychiatric population inadequately and often inappropriately" (Mayo, 2004). Within the context of micro practice, there is currently a need for more culturally diverse and culturally competent mental health professionals (Mayo, 2004). Micro level practitioners are usually the first line of professionals to interact with and work on behalf of clients (Hepworth et al., ch. 2). Considering this fact, if a micro practitioner holds unconscious biases and or is untrained or unfamiliar with working with African American clients, it could possibly further perpetuate the reluctance of service utilization, and therefore add the current social problem.

At the macro and policy levels, there is a need for increased advocacy for African American clients on a larger scale (U.S. Department of Health and Human Services, 2001). There is a need for more community advocacy, and education projects, which would make an active attempt to promote mental health in the African American community, and also provide advocacy and information to clients who are involved in the mental

health system (U.S. Department of Health and Human Services, 2001). Furthermore, there is a need for more codified and artifact typed information and guidelines on working with African American clients. For example, there is an extensive handbook on African American consumer driven mental health standards created by a national panel of African American mental health and social service practitioners, which presents concrete guidelines on working with African American clients (The National Panel on Managed Mental Health Services for Consumers of African Descent, 1997). The problem is that these consumer guidelines have yet to be recognized and canonized by the Department of Health Services (The National Panel on Managed Mental Health Services for Consumers of African Descent, 1997). Lack of policies and advocacy regarding the treatment, training, and funding resources, could possibly also greatly perpetuate the issue of under utilization of mental health services among African Americans.

Purpose of the Study

Considering the scope of the problem presented previously, and due to a request from the Surgeon General for more research on the topic of African American mental

health service utilization (U.S. Department of Health and Human Services, 2001), the purpose of this study was to perform an in depth examination of the major factors that increase the reluctance among African Americans to seek mental health treatment. Additionally, this study sought to investigate intra-group patterns (similarities and differences) across demographic variables in African Americans, as they relate to mental health treatment seeking.

Significance of the Project for Social Work

The current proposed study can contribute to social work practice in several ways. First off, the current study is useful in adding to the existing body of research that has already been done on this topic. This issue of African Americans and mental health is fairly new, and more knowledge is needed to assist in improving the mental health service delivery to the African American population (Davis & Ford, 2004). Moreover, a study of this nature has not yet been conducted in the Southern California area, and will assist in understanding the barriers and needs of the local African American population, with regards to this issue.

Secondly, on a micro level, this study can provide insight to practitioners on factors that increase reluctance in African American clients when considering mental health, which can help them develop appropriate interventions that will yield maximum outcomes when working with African American clients. According to the Council on Social Work Education, culturally competent social work practice is a very important issue (as cited in Johnson, Davis, & Williams, 2004), and this research can assist social workers in becoming more culturally competent when working with diverse populations.

Lastly, on a macro level, knowing and understanding the reluctance factors concerning service utilization can serve as a catalyst for advocacy and change. Social problems are difficult to solve until they are identified and recognized (Brueggemann, 2006, ch. 2). Hence, fully understanding the scope of issues surrounding the reluctance among African Americans to seek mental health treatment is critical information that can provide a strong foundation for policy implementation. With regards to African Americans and mental health treatment, there is clearly a lapse in service utilization, and understanding this fact illustrates the importance to work to create more effective and efficient means of ensuring that the

mental health needs of African Americans are properly addressed.

Summary

As presented in the fore sections, the under utilization of mental health services among African Americans has become a social problem that needs to be addressed immediately to ensure that the future mental health of African Americans will be properly managed and treated. Using the literature as a guide, the researcher this study sought to explore the factors that increase reluctance to seek mental health among African Americans. Results from this study will assist social workers deepen their understanding of how to better serve African American clients in the mental health system.

CHAPTER TWO

LITERATURE REVIEW

Introduction

Chapter Two consists of a review of the relevant literature. This review is divided into four sections: Racial factors and mental health treatment, religious and spiritual factors and mental health treatment, personal and cultural values and mental health treatment, and help seeking attitudes and behaviors and mental health treatment. This chapter also discusses two major theories that guide the conceptualization of this study.

Racial Factors

Historically, African Americans were not thought to be competent enough to suffer from mental illness, and attempting to run from slavery was one of the only diagnosed mental problems in African Americans (Moffic, 2003). Flashing forward to present, Neighbors, Trierweiler, Ford, and Muroff (2003), noted current racial issues and clinical biases, surrounding diagnosis and treatment with African American clients (2003). Additionally, Schwartz et al., (2005) also found evidence of racial bias with diagnosis and treatment at an inner city mental health clinic where clients with PTSD were

often mis-diagnosed (2005). In another similar study, Barnes (2003) found that African Americans were four times more likely to receive a diagnosis of schizophrenia compared to their white counterparts (2003).

These findings highlight the fact that there are still racial barriers in the delivery of services for African Americans. Furthermore, these studies are extremely significant because they show that there are some critical issues with proper assessment and diagnosis of African American patients in regards to their mental health. According the NAMI Multicultural Action Center, "the culture biases of mental health professionals and health care professionals in general prevent many African Americans from accessing care due to prior experiences with historical misdiagnoses, inadequate treatment, and a lack of cultural understanding (2004). Considering the facts presented, there are some obvious racial flaws with how mental health services are delivered to African Americans clients, which may perhaps be a factor in increasing reluctance of mental health treatment seeking.

Religious and Spiritual Factors

Ellison's review of the literature (1998) showed that religious involvement among African Americans has

contributed to increasing their life satisfaction and physical health, and decreasing their mortality and psychological distress and depression (1998). Johnson, Elbert-Avila, and Tulsky (2005) noted that spirituality is very important among African Americans, and that African Americans view spirituality as providing comfort, support and understanding of a given illness (2005).

Researchers have also noted that spirituality among African Americans plays a central role in guiding decisions about health care (Johnson, Elbert-Avila, & Tulsky, 2005). "According to Clark-Tasker (1993), many African Americans believe that illness may be due to a failure to live according to God's will and an acceptance of fate and destiny. For example, many believe that God is in control of their health and that healing can come only through prayer and faith in God" (as cited in Swanson, Crowther, Green, & Armstrong, 2000, p. 82). Moreover, Ayalon & Young (2005) showed that African American college students more often utilized religious services for mental health help seeking in lieu of using the traditional means of professional mental health services (2005).

These studies are important in showing that religion is very important in the African American community. Furthermore, the church in the African American community,

does not only serve as a religion asset, but also as a psycho-social asset as well. According to Caldwell (2001), the African American Church is extremely vital as a social support resource among African Americans (2001). This notion may reveal that there is a possibility that African Americans may feel a reluctance to seek help from traditional mental health treatment services, based on a preference employ religious and church services.

Personal and Cultural Values

As with any cultural history, African American cultural history has had a strong role in shaping the values, attitudes, and perceptions of African Americans concerning issues related to mental health, and health care (Kendall, 1996). Therefore, in understanding why African Americans may be reluctant in some cases to seek or maintain mental health treatment, it is essential to review the personal and cultural attitudes held by African Americans regarding mental health services.

Keating and Robertson (2004) sought to understand if there was fear of mental health service use among Blacks. This study found that participants had many fears and concerns related to mental health, and that many participants had a general mistrust of the mental health

system (Keating & Robertson, 2004). Additionally, some participants commented on having a fear or apprehension when hearing diagnoses such as schizophrenia, and also a general fear of the process and outcomes of treatment (Keating & Robertson, 2004).

Another study, similar to the previous, found parallel perceptions of mental health treatment. For example, the study noted that cultural mistrust, stigma of mental health disorders such as schizophrenia, and the perception that mental health professionals would not understand, nor care about them, were factors that discouraged African Americans from seeking treatment (Thompson, Bazile, & Akbar, 2004).

Researchers also found that participants reported a high desire to work out issues within the family first rather than seeking mental health treatment (Thompson, Bazile, & Akbar, 2004), and that African Americans tended to view life stressors as normal, and part of the African American experience, not necessarily requiring treatment (Thompson, Bazile, & Akbar, 2004). Furthermore, participants in to study reported that there is a need for African Americans to not show weaknesses, but rather to stay strong throughout life trials and hardships (2004).

Help Seeking Attitudes and Behaviors

To understand why African Americans are under represented in mental health treatment centers, it is useful to understand the general help seeking attitudes and behaviors of African Americans. For example, Snowden (1998) showed that as compared to their white counterparts, African Americans were much less likely to seek informal support from persons in their mezzo system such as friends, family, and or religious leaders, implying that help seeking, in general, is low for African Americans (1998).

Moreover, So, Gilbert, and Romero, showed that with regard to African American college students, though mental health help seeking was low, students with more credits and more courses, had much more confidence in mental health treatment as a viable option (2005). Sheu and Shelacek (2004), found that although African American report a willingness to seek professional help, that when they do seek help, they tend to do so for more informal and impersonal reasons, such a economic and education assistance, and less often for emotional and personal reasons.

Tidwell (2004), who studied the 'the no show-phenomenon' among African American women, found that

African American women who canceled or missed mental health appointments, exhibited traits consistent with resistance of the mental health system (Tidwell, 2004). Additionally, a study conducted by Ward (2005) sought to uncover what factors effect participation during the treatment process (2005). The study found that the race of the therapist, familiarity with therapist (especially in drug and alcohol issues), and involvement in the court system all had a significant impact participation (2005).

Theories Guiding Conceptualization

Two theories that facilitate understanding and conceptualization of the reluctance among African Americans to seek mental health treatment are the Theory of Reasoned Action and The Behavioral Model of Health Services. According to the theory of Reason Action, "a person's intention to perform a specific behavior is a function of two factors: 1) attitude (positive or negative) toward the behavior and 2) the influence of the social environment (general subjective norms) on the behavior" (Campbell, 2001). Therefore this theory considers the importance personal and environmental influences on seeking health care, and thus highlights the

possibility that internal and external factors can influence mental health treatment seeking.

A second theory that was used in this study to guide conceptualization was the Behavioral Model of Health Services Use. This theory suggests that "people's use of health services is a function of their predisposition to use services, factors which enable or impede use, and their need for care" (Andersen, 1995). Fundamentally, this theory explains that there are various types of aspects that come into play, which can influence health care service use. The current study will use both theories as a guide to exploring and explaining the factors that are most likely to increase reluctance to seek mental health treatment among African Americans.

Summary

The literature important to this study was presented in chapter two. According to the literature, racial, cultural, religious, and behavioral issues were all importance concepts to explore when seeking to understand and explore the reluctance among African Americans to seek mental health treatment. The present study sought to then examine which type of factors played the largest and most significant role leading to reluctance of African American

mental health seeking. Better understanding these factors can lead to better service delivery, and improved interventions and treatment outcomes.

CHAPTER THREE

METHODS

Introduction

Chapter Three documents the steps used in developing the project. Specifically, this chapter will cover the research design and methods concerning sampling, data collection, instrument, procedures, data analysis, and chapter summary.

Study Design

This study was designed to explore the factors that contribute to the reluctance to seek mental health treatment among African Americans. Current literature notes that sources of reluctance could stem from factors such as stigma, lack of money, fear, spirituality, etc. This study sought to assess which factors were most significant in determining the reluctance of mental health treatment seeking among African Americans.

This study can be beneficial to social work practice as it will add to the foundation of social work knowledge, and will lead to improved micro and macro social work practices, which will assist increasing the utilization of mental health services in the African American community. This study used a quantitative survey design to obtain

information from participants regarding their reluctance to seek mental health treatment. Again, this study examined the factors that are most commonly associated with the reluctance mental health treatment seeking among African Americans.

Sampling

African American study participants from the Black Infant Health Program and from Lifeway Church were solicited to complete a quantitative questionnaire about their reluctance to seek mental health treatment. The two agencies where data collection took place were chosen primarily for their high density of potential African American participants. The Black Infant Health Program had many participants who were low income and who were more at risk for institutionalization. Lifeway Church provided participants with a wider age range, higher income, and who had a strong religious identification. These two agencies provided a wide variety of African American participants, which led to a more comprehensive sample, and increased external validity.

Participants in the study were African American, either male or female, and over the age of 18 (There was no upper bound age limit for participants). The study

included all persons of African descent who live in America, but the survey sought to differentiate the specific identified heritage of participants (African American, African Latin, African Caribbean, African Indian, African, and Mixed Race).

The purpose of using both men and women in the study was to determine if there were any major differences across gender in the factors that contribute to reluctance to seek mental health treatment among African Americans. Additionally the study used participants of various ages (over 18), as a way to uncover any differences across age. As with the variables of gender and age, this study also examined several other demographic variables for the purpose of a complete intra-group analysis.

Data Collection and Instruments

Data was collected from 53 participants via an administered quantitative survey. The survey consisted of 40 questions in total; 29 of these questions were based on a likert scale, 9 were multiple-choice questions concerning demographics, and 2 were open-ended fill-ins. The likert scale questions measured the participants' opinions of and identification with particular mental health treatment reluctance factors.

The data collection instrument was adapted by the researcher using the standardized Attitudes toward Seeking Professional Help scale (Fischer & Turner, 1979) and additional variables based on key themes in the literature. The strength of the research instrument is that it was a standardized scale that was adapted to be specifically tailored to the study. The limitation of the instrument is that comprehensively the instrument has not been tested for reliability.

The independent variables that the instrument addressed were demographic information such as: religion, age, education, socioeconomic status, gender, mental health service use history, incarceration history, drug use history, and child welfare system history. The dependent variables that were measured in the survey were the factors that contribute to the reluctance of mental health treatment seeking among African Americans.

Procedures

The collection of data began in January 2007, after the approval from the Institutional Review Board Social Work Subcommittee was obtained. Participants for this study were notified about the study via announcement. At the Lifeway church site, participants were notified during

the mid-week bible study via announcement. At the Black infant health program, the participants were also be notified during a weekly client meeting. Once the announcement was made, interested participants were directed to a room to meet the researcher if they decided to participate in the study. The room was equipped with tables and chairs for participants to complete the survey. The researcher was also in the room with all of the needed materials. As participants entered the room, they were given an informed consent, the study, and a writing implement, by the researcher. They were asked to read the front page (the informed consent) and told that if they decide to participate, to continue following the directions. They were also informed to see the researcher when they were finished, or if they had any questions. Participants then read the informed consent to decide if they were willing to participate in the study. If participants were willing to participate they placed an x on the informed consent and proceeded to complete the survey. The survey took approximately 10-15 minutes to complete. Once complete, participants were directed to return the survey, the informed consent, and the writing implement to the researcher. The researcher then thanked

each person for their participation and handed them a debriefing statement.

Protection of Human Subjects

Anonymity of participants was maintained by only having participants 'mark an x' instead of signing the informed consent form for participation. There was no other identification requested from, or notated about the participants. With regards to confidentiality, all participants were able to complete surveys in a separate room, away from the rest of the organizations clients. Completed surveys were kept in a secured box with a lock at the researcher's home. Completed surveys were only made available to the researcher and the faculty supervisor. With the approval of the department, the surveys were shredded upon the completion of the research study.

Data Analysis

This study was analyzed using a quantitative data analysis approach. Descriptive statistics including the frequency distribution and the measures of central tendency (e.g., means) and dispersion (e.g., standard deviations) were used to describe and summarize the data. Inferential statistics such as chi-square tests, Pearson's correlation coefficients, and t-test were also used to

assess the associations or relationships between the independent and dependent variables.

Summary

This study used a 40 item quantitative survey to measure the variables that were most significant and correlative with the reluctance of mental health treatment seeking among African Americans. Statistical tests were used to determine frequencies and correlations.

CHAPTER FOUR

RESULTS

Introduction

Included in Chapter Four is a presentation of the findings. Using measures of central tendency, and chi-square analyses, the findings from the 40-item scale are categorized and presented. Lastly, the Chapter concludes with a summary.

Presentation of the Findings

Demographic Characteristics of the Participants

Table 1 shows the demographic characteristics of the participants. There are a total of 53 African American participants in the study sample. The age range of the sample is from 18 to 78 years. Over half of participants (52.8%) were between the ages of 18 and 30, 28.3% between 31 and 40, 11.3% between 41 and 50, and 3.8%, 51 years or older. The majority of the participants in the study sample identified as African American 92.5%, 5.7% as biracial, and 1.9% as African. With regards to gender, 41.5% were male and 58.5% were female.

Almost half of participants (47.2%) reported that they were single, never married, which could be consistent with high numbers of participants who were between the

ages of 18-30 years. Additionally, 32.1% of the participants were married, 7.5% were divorced or separated, 3.8% were widowed, and 9.4% were cohabitating.

The majority of participants in the study identified as being Christian (88.7%), while 11.3% identified as being spiritual, not religious. Slightly over half of the participants (58.7%) reported that they attended church services at least weekly. Over 11% reported that they attended church a few times a month, 3.8% reported they attended church services once a month, and 26.4% indicated that they attended a few times a year or less.

About half of the participants in the study reported having received some college education (50.9%), 18.9% reported having a high school diploma or GED, 17.0% reported having a college degree, 9.4% reported having no high school diploma, and 3.8% reported having a graduate or professional degree. With regards to income, 32.7% of the participants reported having a monthly income between $1001.00 and $3000.00. Over 21% of the participants reported having an income below $1000.00, and 21.2% reported an income between $3001.00 and $5000.00. Over 13% of the participants reported having an income between $5001.00 and $8000.00, and 11.5% reported having an income over $8000.00, monthly.

Table 1. Demographic Characteristics of Participants

Variable	Frequency (n)	Percentage (%)
Age (N = 53)		
18-30	28	52.8
31-40	15	28.3
41-50	6	11.3
51-60	2	3.8
61+	2	3.8
Ethnicity (N = 53)		
African American	49	92.5
African American (Bi-Racial)	3	5.7
African American (African Immigrant)	1	1.9
Religion Affiliation (N = 53)		
Christian	47	88.7
Spiritual (Not Religious)	6	11.3
Church Attendance (N = 53)		
More than once a week	15	28.3
Once a week	16	30.2
Few times a month	6	11.3
Once a month	2	3.8
Few times a year	4	7.5
Rarely	7	13.2
Never	3	5.7
Gender (N = 53)		
Male	22	41.5
Female	31	58.5
Marital Status (N = 53)		
Single, never married	25	47.2
Married	17	32.1
Separated/Divorced	4	7.5
Widowed	2	3.8
Cohabitating	5	9.4
Education (N = 53)		
No H.S. Diploma	5	9.4
H.S. Diploma	10	18.9
Some College	27	50.9
College Degree	9	17.0
Graduate Degree	2	3.8
Monthly Income		
> 1001.00	11	21.2
1001.00 - 3000.00	17	32.7
3001.00 - 5000.00	11	21.2
5001.00 - 8000.00	7	13.5
< 8001.00	6	11.5

Participants Personal Involvement with Institutions/Systems

Table 2 shows participants' personal involvement with Institutions/Systems, such as Child Welfare, Criminal Justice, Mental Health, Social Services, Homeless Services, and Substance Abuse Services. There were five participants who left items in this section blank and therefore they are not included in the percentages. About 11% of the participants reported involvement with the child welfare system, 9.4% of participants reported involvement with the criminal justice system, 18.9% of participants reported involvement with the Department of Social Services, 17.0% of participants reported involvement within the mental health care system, 11.3% reported using homeless services at some point in time, and 15.0% of participants reported utilization of substance abuse services. There were no associations of statistical significance found with regard to personal involvement with social systems, and attitudes or reluctance toward mental health treatment.

Table 2. Participants' Involvement with Institutions/Systems

Variable	Frequency (n)	Percentage (%)
Child Welfare Services		
Yes	6	11.3
No	42	79.2
Criminal Justice System		
Yes	5	9.4
No	43	81.1
Department of Social Services		
Yes	10	18.9
No	38	71.7
Mental Health Services		
Yes	9	17.0
No	39	73.6
Homeless/Housing Services		
Yes	6	11.3
No	42	79.2
Substance Abuse Treatment Services		
Yes	8	15.0
No	40	75.5

Attitude toward Seeking Professional Help

Table 3 shows the participants' responses to the items of the Attitudes toward Seeking Professional Help scale (Fischer & Tuner, 1979). The scale is separated into four different factor areas. Factor I is Recognition of need for psychotherapeutic help (Questions: 4, 5, 6, 9, 18, 24, 25, 26), and measures the extent to which the participants recognized their need for help. Factor II is Stigma Tolerance (Questions: 3, 14, 20, 27, and 28) and measures how stigma affects the attitudes of participants and professional help seeking. Factor III is Interpersonal

Openness (Questions: 7, 10, 13, 17, 21, 22, and 29) and measures participants' attitudes towards interpersonal disclosure of professionals. The last factor, Factor IV, is confidence in mental health practitioner (Questions: 1, 2, 8, 11, 12, 15, 16, 19, and 23), and measures respondents' level of confidence in mental health providers.

Based on the responses of the participants, Factor I: Recognition of the need for psychotherapeutic help, showed both a high value of interpersonal strength, but also an overall acknowledgment when help is necessary. For example, for item 4, A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist, The results were almost equal showing the 52.8% of participants either 'agree' or somewhat agree. Additionally, for item 26, A person should work on their own problems; getting psychological counseling would be a last resort, 64.1% of participants also 'agreed' or 'somewhat agreed' with that statement.

Table 3. Participants' Attitudes towards Seeking Professional Help - Factor I: Recognition of Need for Psychotherapeutic Help

Item	Frequency (n)	Percentage (%)
4. A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.		
Agree	14	26.4
Somewhat Agree	14	26.4
Somewhat Disagree	9	17.0
Disagree	16	30.2
5. There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem.		
Agree	27	50.9
Somewhat Agree	17	32.1
Somewhat Disagree	4	7.5
Disagree	5	9.4
6. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.		
Agree	12	22.6
Somewhat Agree	16	30.2
Somewhat Disagree	9	17
Disagree	16	30.2
9. Emotional difficulties, like many things, tend to work out by themselves.		
Agree	13	24.5
Somewhat Agree	14	26.4
Somewhat Disagree	9	17.0
Disagree	17	32.1

Item	Frequency (n)	Percentage (%)
18. I would want to get psychiatric attention if I was worried or upset for a long period of time.		
Agree	20	37.7
Somewhat Agree	15	28.3
Somewhat Disagree	7	13.2
Disagree	11	20.8
24. There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.		
Agree	17	32.1
Somewhat Agree	9	17.0
Somewhat Disagree	9	17.0
Disagree	18	34.0
25. At some future time I might want to have psychological counseling.		
Agree	18	34.6
Somewhat Agree	11	21.2
Somewhat Disagree	5	9.6
Disagree	18	34.6
26. A person should work on their own problems; getting psychological counseling would be a last resort.		
Agree	20	37.7
Somewhat Agree	14	26.4
Somewhat Disagree	8	15.1
Disagree	10	18.9

Participants also responded in a consistent manner for items, 6, 9, and 24, which suggest that participants have a strong value for self-reliance. On the other hand, within this category, participants, in addition to the high values of self-reliance, also seem to be open to psychotherapeutic help if necessary. This is indicated by

the results for item 5, where 92.0% of participants 'agreed or somewhat agreed' with the statement: There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem. Similarly 66.0% of the participants reported that they would want to get psychiatric attention if they were worried or upset for a long period of time. Results for factor one seem to show that although there is a strong value for self-reliance among participants, there is also recognition for the need of and openness for mental health treatment in certain circumstances.

With regards to factor II: Stigma Tolerance, there seems to be an almost even number of participants who indicated a high level of stigma tolerance, and compared with those who don't (see Table 4). This is illustrated in the almost evenly divided percentages on items 3, 14, and 20. However, for item 28, If I thought I need psychiatric help, I would get it no matter who know it, 76.9% of participants either 'agreed' or 'somewhat agreed with that statement. These results show that while there seems to be an elevated level of stigma tolerance for mental health treatment seeking, among participants in the sample, there is also a divided attitude on stigma tolerance for participants in the study.

Table 4. Participants' Attitudes towards Seeking Professional Help - Factor II: Stigma Tolerance

Item	Frequency (n)	Percentage (%)
3. I would feel uneasy going to a psychiatrist because of what some people would think.		
Agree	11	20.8
Somewhat Agree	11	20.8
Somewhat Disagree	9	17
Disagree	22	41.5
14. Having been a psychiatric patient is a blot on a person's life.		
Agree	15	28.3
Somewhat Agree	9	17.0
Somewhat Disagree	12	22.6
Disagree	17	32.1
20. Having been mentally ill carries with it a burden of shame.		
Agree	11	20.8
Somewhat Agree	13	24.5
Somewhat Disagree	12	22.6
Disagree	17	32.1
27. Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."		
Agree	14	26.4
Somewhat Agree	12	22.6
Somewhat Disagree	12	22.6
Disagree	15	28.3
28. If I thought I needed psychiatric help, I would get it no matter who knew it.		
Agree	21	40.4
Somewhat Agree	19	36.5
Somewhat Disagree	4	7.7
Disagree	8	15.4

Table 5 presents the frequency distribution of the items in Factor III, interpersonal openness. There appears to be positive attitude toward being open with professionals. For example, 83.0% of the participants 'agreed' or 'somewhat agreed' to item 7 - I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. Additionally, for item 17, I resent a person- professionally trained or not- who wants to know about my personal difficulties, the great majority (75.0%) of participants either 'somewhat disagreed' or 'disagreed'.

Table 5. Participants Attitudes towards Seeking Professional Help - Factor III: Interpersonal Openness

Item	Frequency (n)	Percentage (%)
7. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.		
Agree	32	60.4
Somewhat Agree	12	22.6
Somewhat Disagree	3	5.7
Disagree	6	11.3
10. There are certain problems which should not be discussed outside of one's immediate family		
Agree	18	34.0
Somewhat Agree	11	20.8
Somewhat Disagree	8	15.1
Disagree	16	30.2

Item	Frequency (n)	Percentage (%)
13. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.		
Agree	12	23.1
Somewhat Agree	13	25.0
Somewhat Disagree	8	15.4
Disagree	19	36.5
17. I resent a person-professionally trained or not-who wants to know about my personal difficulties.		
Agree	6	11.5
Somewhat Agree	7	13.5
Somewhat Disagree	13	25.0
Disagree	26	50.0
21. There are experiences in my life that I would not discuss with anyone.		
Agree	22	41.5
Somewhat Agree	16	30.2
Somewhat Disagree	3	5.7
Disagree	12	22.6
22. It is probably best not to know everything about oneself.		
Agree	12	22.6
Somewhat Agree	5	9.4
Somewhat Disagree	14	26.4
Disagree	22	41.5
29. It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.		
Agree	16	30.2
Somewhat Agree	5	9.4
Somewhat Disagree	5	9.4
Disagree	27	50.9

These results show that participants' in the study show an overall receptiveness to discussing interpersonal matters with professionals. However, interpersonal

openness may be reduced to only certain topics. This is demonstrated in that 71.7% of participants 'agreed' or somewhat' agreed with the statement, There are experiences in my life I would not discuss with anyone. The results for items in factor 3 show that although respondents reported being interpersonally open with mental health professionals, there is a limit on what they are willing to discuss with professionals.

Factor IV, confidence in mental health practitioners, is another area that has great division among respondents (see Table 6). Items 8, 11, and 16, were nearly equally divided in participants' responses. Moreover, participants showed divergence in their responses for factor 4. For example, for item 2, If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist, The majority (77.4%) of the participants reported that they either 'agreed' or 'somewhat agreed' with the statement. Additionally, for item 23, If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy, 60.4% of the participants 'agreed' or 'somewhat agreed' with the statement. These responses show that participants have a high level of confidence mental health professionals. On the other hand, other responses

showed a lower level of confidence of mental health professionals. From the sample, 56.6% of participants responded that they 'agreed', or 'somewhat agreed' with the statement, although there are clinics for people with mental troubles, I would not have much faith in them. Likewise, for item 15, I would rather be advised by a close friend than by a psychologist, even for an emotional problem, 56.6% of the participants 'agreed', or 'somewhat agreed'. Based on the varying responses, it is difficult to assess the level of confidence the participants' have for mental health professionals due to the deviated responses of participants.

Table 6. Participants' Attitudes towards Seeking Professional Help - Factor IV: Confidence in Mental Health Practitioner

Item	Frequency (n)	Percentage (%)
1. Although there are clinics for people with mental troubles, I would not have much faith in them.		
Agree	17	32.1
Somewhat Agree	13	24.5
Somewhat Disagree	12	22.6
Disagree	11	20.8

Item	Frequency (n)	Percentage (%)
2. If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.		
Agree	24	45.3
Somewhat Agree	17	32.1
Somewhat Disagree	7	13.2
Disagree	5	9.4
8. I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.		
Agree	8	15.1
Somewhat Agree	14	26.4
Somewhat Disagree	7	13.2
Disagree	24	45.3
11. A person with serious emotional disturbance would probably feel more secure in a good mental hospital		
Agree	14	26.9
Somewhat Agree	16	30.8
Somewhat Disagree	9	17.3
Disagree	13	25.0
12. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.		
Agree	18	34.6
Somewhat Agree	15	28.8
Somewhat Disagree	6	11.5
Disagree	13	25.0
15. I would rather be advised by a close friend than by a psychologist, even for an emotional problem.		
Agree	14	26.4
Somewhat Agree	16	30.2
Somewhat Disagree	9	17.0
Disagree	14	26.4

Item	Frequency (n)	Percentage (%)
16. A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.		
Agree	10	18.9
Somewhat Agree	20	37.7
Somewhat Disagree	12	22.6
Disagree	11	20.8
19. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.		
Agree	10	19.2
Somewhat Agree	7	13.5
Somewhat Disagree	14	26.9
Disagree	21	40.4
23. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.		
Agree	17	32.1
Somewhat Agree	15	28.3
Somewhat Disagree	19	18.9
Disagree	11	22.8

Reluctance Factors for Seeking Mental Health Treatment

Table 7 presents the reluctance factors for seeking mental health treatment. The 10 items for the scale were created by the researcher, and chosen as relevant reluctance factors from the literature. Of the participants in the sample, 50.9% reported a reluctance to seek mental health treatment, because I would not have the money or insurance to pay for services, which indicates a services access barrier. Additionally, almost half of the

participants (49.1%) reported that they might be reluctant to seek mental health treatment, because I would rather handle my problems on my own. This finding is consistent with previous finding of a strong value for self-reliance in the sample. The least reported factors for reluctance for seeking mental treat were, because it would be showing lack of faith in God (28.0%), and because I really don't think that it would be helpful for me (24.5%). These findings show that religion and spiritually do not significantly increase the reluctance of seeking mental health treatment. Additionally, the findings show that reluctance of mental health treatment seeking does not seem to be significantly impacted by the lack of confidence in mental health professionals.

Table 7. Reluctance Factors (If I was Experiencing a Serious Emotional Crisis or Problem, I Might be Hesitant to see a Mental Health Professional Because...)

Item	N	Frequency (n)	Percentage (%)
1. Because they use their clients' information for statistics and reports.	53	21	39%
2. Because it would be showing lack of faith in God.	53	15	28%
3. Because I would not have the money or insurance to pay for services.	53	27	50.9%
4. Because I really don't think that it would be helpful for me.	53	13	24.5%
5. Because they do not really care about me or my problems.	53	18	34.0%
6. Because I don't like to talk about my problems with people I don't know.	53	21	39.6%
7. Because they would not really understand me, or where I am coming from.	53	24	45.3%
8. Because I would not want to be labeled as "crazy" or "weak".	53	18	34.0%
9. Because I would not really be able to trust a mental health Therapist.	53	18	34.0%
10. Because I would rather handle my problems on my own.	53	26	49.1%

Chi-Square Analysis

A series of chi-square tests were conducted to assess associations between gender and the 39 dependent variables on the survey instrument (the 29 item Attitude towards

seeking professional help scale, and the 10-item reluctance factor scale). A total of three items came out to be statistically significant. There was a statistically significant association between gender and item 8: I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment. (Chi-square = 8.64, df = 3, p = .034). This chi square analysis shows that African American males tended to have less confidence in mental health practitioners that did females. Additionally, statistical significance was also shown between gender and item 20: Having been mentally ill carries with it a burden of shame (Chi-square = 9.2, df = 3, p = .034). African American males had a lower tolerance for stigma than did females in the study.

Lastly, there was a statistically significant association between gender and item 10: If I were experiencing a serious emotion problem, I may be hesitant to seek mental health treatment because I would rather handle my problems on my own (Chi-square = 5.5, df = 1, p = -.019). This finding reveals that more males tended to report reluctance based on the desire to handle the mental health problems on their own.

Summary

Chapter Four presented the results extracted from the data. Although there was a division in participants' responses, overall, attitudes were favorable toward seeking professional mental health help. With regards to reluctance, the most significant reluctance factors were lack of sufficient financial resources, having a strong self reliance, and a perceived lack of understanding in mental health professionals. The least significant reluctance factors were religiosity, and need recognition. Finally, a chi square analysis showed a gender difference in the reluctance factors among African Americans and seeking mental health treatment.

CHAPTER FIVE

DISCUSSION

Introduction

Included in Chapter Five was a presentation of the discussion and conclusions gleaned as a result of completing the project. Further, the recommendations extracted from the project are presented. Lastly, the Chapter concludes with a summary.

Discussion

The purpose of this study was to uncover the major factors that contribute to the reluctance of mental health treatment seeking among African Americans. According to the literature, African Americans underutilize outpatient mental health treatments services, such as clinics and counseling centers, and overutilize emergency hospital or inpatient treatment services (U.S. Department of Health and Human Services, 2001). This study was important because social workers need to be aware of the major reluctance factors that inhibit African Americans from seeking mental health treatment so that intervention strategies can be created to help reduce reluctance, and increase outpatient mental health treatment utilization.

Of the factors studied, those most consistent with the reluctance to seek mental health treatment included: lack of affordable access to treatment and high level of self-reliance. The participants in the study were more likely to report that lack of money or insurance to pay for services would be a reason for being reluctant to seek mental health treatment. According to the U.S. Department of Health and Human Services, "nearly one-fourth of African Americans are uninsured (as cited in Brown et al., 2000), a percentage 1.5 times greater than the white counterparts. In the United States, health insurance is typically provided as an employment benefit (U.S. Department of Health and Human Services, 2001). Furthermore, service accessibility is a key factor to services delivery according to the Behavioral Model of Health Services, which explains that "...health personnel and facilities must be available where people live and work...and people must have the means and know-how to get to those services and make use of them" (Andersen, 1995, p. 3). Furthermore, this model explains that two important factors of enabling a person to seek health care services are income and health insurance (Andersen, 1995). Based on the behavioral model of health services, service

accessibility also appears to be a crucial factor related to service utilization among African Americans.

In addition to service accessibility issues, a high level of self-reliance also seemed to be very significant among participants in the sample. According to Chapman and Mullis (2000), Self-reliance has generally been described as a coping mechanism that is more commonly observed among racial minority groups rather than Anglo populations.

This could be a very important finding that should be researched further due to the fact that high level of self reliance could, not only, greatly impinge on the utilization of mental health treatment use, but more importantly, could emerge as a cultural factor in the way that African Americans approach mental health services. For instance, Ortega and Alegria (2002) found that the more self reliant a person was, the less effective they would view mental health services, and the less likely they would be to utilize them.

Unlike service accessibility and self-reliance, which were most consistent with the reluctance to seek mental health treatment, there were some factors that did not appear to be consistent with such reluctance. For instance, neither religiosity nor stigma appeared to have a direct impact on reluctance to seeking mental health

services. This finding is inconsistent with the literature, where Ward (2005) notes new theories emerging on religiosity of African Americans and its role in mental health treatment reluctance. In the current study, the majority of participants reported being Christian, and over half reported attending church services at least weekly. Although many of the participants in the study appeared to have a high level of religious involvement, nevertheless, many participants still reported favorable attitudes toward mental health treatment services, and furthermore, did not respond that their faith would lead to increased reluctance of seeking mental health treatment.

With regards to stigma, studies have reported that stigma related to mental illness and treatment was a barrier to the utilization of mental health services (Thomson, Bazile, & Akbar, 2004), However, the majority of participants in the current study did not select "the fear of being labeled" as a major factor leading to reluctance of seeking mental health treatment.

Other inconsistencies of this study with the current literature are regarding varying levels of reluctance based on the education level of African Americans. For example, So Gilbert and Romero (2005) reported that

education had a positive correlation with positive attitudes toward seeking mental health treatment among African Americans. However, in the present study, there were no significant educational differences in the reluctance of African Americans to seek mental health treatment.

There appears to be a gender difference with regards to attitudes and reluctance toward seeking mental health treatment. African American men were more likely to show higher rates of reluctance than African American women. Again, African American men tended to exhibit less favorable attitudes toward seeking mental health treatment than their African American counterparts in the study. Boyd-Franklin (1989) suggests that ... "the socialization of African American men, which, influenced by racism and discrimination, has led to the development of the "macho" role, preventing African American men from showing weakness during difficult times. Many African American men may see any admission of emotional problems to people outside the family network as a sign of "weakness" (as cited in Paniagua, 2005, p. 37).

This is a very important finding that deserves further attention. African American men, according to Thorn and Sarat (1998), are at high risk for experiencing

violent crimes, suffer from substance abuse, and have involvement in the legal system (1998). Furthermore, African American males are over-represented in inpatient psychiatric settings (Thorn & Sarat, 1998), and also have shown to have increasing rates of suicide (U.S. Bureau of the Census, 1996). These findings may indicate African American males' strong need for mental health and other services. In order to increase African American males' access to mental health services, innovative approaches or methods need to be considered.

Limitations

The current study did have some limitations that are important to note. First, the sample size of the study was very small (N = 53), and therefore, compromises the external validity of the results. Moreover, with regards to the sample, there was an overrepresentation of young adults between the ages of 18-30, which hinders the generalizability of the findings to other age groups, who were underrepresented in the study.

Another threat to the external validity of the study has to do with the availability sampling method utilized. Because the study did not use a random sample, a truly representative African American sample, was not obtained.

Additionally, because the majority of the data was collected from a local non-denominational Christian church, the data is likely to be somewhat skewed based on the fact that the majority of participants are from the same religious organization. This limitation not only affects generalizability, but also my affect inconsistencies of findings with the current literature.

Recommendations for Social Work Practice, Policy and Research

Despite its limitations, the findings of this study elicit some very important recommendations for social work practice. With regards to micro social work practice, some recommendations are to enlighten and encourage social work practicitioners of the need to be aware of the reluctance and resistance factors among African Americans. This needed awareness is related to the ever increasing need for social workers, and other social and health practitioners to be culturally sensitive in their practice and dealings with diverse clients (Johnson, Davis, & Williams, 2004). Furthermore, social workers should strive to be aware of and utilize therapeutic strategies and best practices with African American clients based on sound experience, research and training. For example, the Consumer-Driven Standards and Guidelines in Managed Mental

Health for Populations of African Descent (The National Panel on Managed Mental Health Services for Consumers of African Descent, 1997) succinct guidelines for practitioners working with African American clients. These Guidelines can serve as a beginning resource for social workers obtaining valuable information about serving African Americans. With specific regard to working with African American men, the way that clinicians approach services may need to be altered. For example, Robertson and Fitzgerald (1992) found in their study, that males tended to respond more favorably to seeking help when services were promoted as psycho-education rather than as psychotherapy (1992).

A final recommendation for micro and macro social work practitioners is to increase mental health service access for potential consumers. Local clinics and practices should make more efforts to disseminate information to the African American community regarding the availability of their services. Additionally, more outpatient clinics should be willing to offer sliding scale programs and social workers should assist client navigate to complicated social services systems to find low cost services. Social Workers should make advocating for low cost services a priority and efforts should be

made to ensure economical services for not only low income consumers, but also working class consumers who are uninsured.

Furthermore, continuing on the need for affordable health care services, there needs to be increased efforts of advocacy for Health Care Coverage for mental health services for underserved populations. This recommendation is extremely important because consumers need to be aware of where they can go to receive affordable mental health services.

Recommendations for research are that further research is definitely recommended surrounding this topic, using a more representative sample, not only to enhance external validity, but to also explore key issues. Future studies should look to specifically explore issues related to service accessibility among African Americans, and also the role that self-reliance play in utilizing mental health treatment. Additionally, it would also be extremely valuable to research the reluctance of African American males towards mental health treatment.

Conclusions

The current study examined the factors that contribute to the reluctance of mental health treatment

seeking among African Americans. Data was collected from 53 participants, using a quantitative survey method with self administered questionnaires. Gender differences were found in their attitudes toward mental health treatment. Lack of access to affordable services and high level of self reliance were found to contribute to reluctance of seeking mental health services among the participants in the study. It is important that policies be implemented that address issue related to barriers to accessing mental health services. Additionally, future research is recommended to explore issues related to self reliance, and reluctance in the African American male population.

APPENDIX A

QUESTIONNAIRE

Questionnaire for Mental Health

Section 1: Attitude Toward Seeking Professional Help

The following statements below are pertaining to mental health issues. Please read each statement carefully and indicate whether you agree, somewhat agree, somewhat disagree, or disagree with the statement. There is no right or wrong answer. So please express your honest opinion in rating the statements.

1 = Agree (A)
2 = Somewhat agree (SA)
3 = Somewhat disagree (SD)
4 = Disagree (D)

1.	Although there are clinics for people with mental troubles, I would not have much faith in them.	1 A	2 SA	3 SD	4 D
2.	If a good friend asked my advice about a mental problem, I might recommend that he see a psychiatrist.	1 A	2 SA	3 SD	4 D
3.	I would feel uneasy going to a psychiatrist because of what some people would think.	1 A	2 SA	3 SD	4 D
4.	A person with a strong character can get over mental conflicts by himself, and would have little need of a psychiatrist.	1 A	2 SA	3 SD	4 D
5.	There are times when I have felt completely lost and and would have welcomed professional advice for a personal or emotional problem.	1 A	2 SA	3 SD	4 D
6.	Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.	1 A	2 SA	3 SD	4 D
7.	I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	1 A	2 SA	3 SD	4 D
8.	I would rather live with certain mental conflicts than go through the ordeal of getting psychiatric treatment.	1 A	2 SA	3 SD	4 D

9.	Emotional difficulties, like many things, tend to work out by themselves.	1 A	2 SA	3 SD	4 D
10.	There are certain problems which should not be discussed outside of one's immediate family	1 A	2 SA	3 SD	4 D
11.	A person with serious emotional disturbance would probably feel more secure in a good mental hospital	1 A	2 SA	3 SD	4 D
12.	If I believed I was having a mental breakdown, my first inclination would be to get professional attention.	1 A	2 SA	3 SD	4 D
13.	Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	1 A	2 SA	3 SD	4 D
14.	Having been a psychiatric patient is a blot on a person's life.	1 A	2 SA	3 SD	4 D
15.	I would rather be advised by a close friend than by a psychologist, even for an emotional problem.	1 A	2 SA	3 SD	4 D
16.	A person with an emotional problem is not likely to solve it alone; he is likely to solve it with professional help.	1 A	2 SA	3 SD	4 D
17.	I resent a person- professionally trained or not- who wants to know about my personal difficulties.	1 A	2 SA	3 SD	4 D
18.	I would want to get psychiatric attention if I was worried or upset for a long period of time.	1 A	2 SA	3 SD	4 D
19.	The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.	1 A	2 SA	3 SD	4 D
20.	Having been mentally ill carries with it a burden of shame.	1 A	2 SA	3 SD	4 D
21.	There are experiences in my life that I would not discuss with anyone.	1 A	2 SA	3 SD	4 D
22.	It is probably best not to know everything about oneself.	1 A	2 SA	3 SD	4 D

23.	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.	1 A	2 SA	3 SD	4 D
24.	There is something admirable in the attitude of a person who is willing to cope with his conflicts and fears without resorting to professional help.	1 A	2 SA	3 SD	4 D
25.	At some future time I might want to have psychological counseling.	1 A	2 SA	3 SD	4 D
26.	A person should work on their own problems; getting psychological counseling would be a last resort.	1 A	2 SA	3 SD	4 D
27.	Had I received treatment in a mental hospital, I would not feel that it ought to be "covered up."	1 A	2 SA	3 SD	4 D
28.	If I thought I needed psychiatric help, I would get it no matter who knew it.	1 A	2 SA	3 SD	4 D
29.	It is difficult to talk about personal affairs with highly educated people such as doctors, teachers, and clergymen.	1 A	2 SA	3 SD	4 D

30. If I was experiencing a serious emotional crisis or problem, I might be hesitant to see a mental health professional because... (place a checkmark by all of the following statements that apply)

1. ___ Because they use their clients' information for statistics and reports.
2. ___ Because it would be showing lack of faith in God.
3. ___ Because I would not have the money or insurance to pay for services.
4. ___ Because I really don't think that it would be helpful for me.
5. ___ Because they do not really care about me or my problems.
6. ___ Because I don't like to talk about my problems with people I don't know.
7. ___ Because they would not really understand me, or where I am coming from.
8. ___ Because I would not want to be labeled as "crazy" or "weak".
9. ___ Because I would not really be able to trust a mental health Therapist.
10. ___ Because I would rather handle my problems on my own.

Section Two: Please circle or fill-in the information that best describes you.

1. How old were you on your last birthday: _____

2. What is your religious affiliation (circle one)?
   1. Agnostic
   2. Scientology/Religious Science
   3. Spiritual (Not Religious)
   4. Muslim/Islamic
   5. Christian (specify denomination): _____
   6. Other (please write in): _____

3. How often do you usually attend church services?
   1. More than once a week
   2. Once a Week
   3. Few times a Month
   4. Once a Month
   5. Few times a Year
   6. Rarely
   7. Never

4. What is your gender?
   1. Male
   2. Female

5. What is your marital status?
   1. Single (never married)
   2. Married
   3. Separated/Divorced
   4. Widowed
   5. Cohabitating (living together)

6. What is the highest level of education that you completed?
   1. Jr. High School
   2. Some High School
   3. H.S. Diploma/GED
   4. Some college
   5. 4 year college degree
   6. Graduate Degree/Professional Degree

7. How do you define your ethnicity (circle one):
   1. Black American
   2. Black Indian
   3. Black Caribbean
   4. Back Latino
   5. Black Biracial/Mixed
   6. Black African (from Africa)
   7. Other: _____

8. Have you ever personally (not professionally) dealt with any of the following?
   1. Yes, If yes then please check all that apply, below.
   2. No
      - ❑ Child Welfare Services (With Child Protective Services, Foster Care, or a Group Home).
      - ❑ Criminal Justice System (In Prison/Jail, Probation, or Parole).
      - ❑ Department of Social Services (Received Welfare, TANF, Cash-Aid, or Disability).
      - ❑ Mental Health Clinic/Hospital Services (In any form of psychotherapy/psychiatric treatment).
      - ❑ Homeless Program/Shelter Services (Received any homeless services).
      - ❑ Substance Abuse Treatment Services (Received any substance abuse treatment).

9. What is your total monthly household income?
   1. Less than $1,000.00
   2. $1,001.00 - $3,000.00
   3. $3,001.00 - $5,000.00
   4. $5,001.00 - $8,000.00
   5. More than $8,000.00

10. How many people total live in your household: _____

Thank you so much for your participation. It is greatly appreciated.

Please turn in the survey to the researcher!

APPENDIX B

INFORMED CONSENT

INFORMED CONSENT

The research study in which you are being asked to participate is designed to explore the factors that affect the reluctance of mental health treatment seeking among African Americans. This study is being conducted by Natalie Majors under the supervision of Dr. Janet Chang, Associate Professor of Social Work. This study has been approved by the Department of Social Work sub-committee of the Institutional Review Board, California State University, San Bernardino. In this study you will be asked to respond to several questions, based on your personal feelings and beliefs. The questionnaire should take about 10 to 15 minutes to complete. All of your responses will be held in the strictest of confidence by the researcher. Your name will not be reported with your responses. All data will be reported in group form only. You may receive the group results of this study upon completion after summer of 2007, at the following location: California State University, San Bernardino, in the Pfau Library. Your participation in this study is totally voluntary. You are free not to answer any questions and withdraw at any time during this study without penalty. When you have completed the questionnaire, you will receive a debriefing statement describing the study in more detail. In order to ensure to validity of the study, we ask that you not discuss this study with other participants. As a result of participating in this research study, it is hoped that you have an increased awareness of the factors that contribute to the reluctance of mental health treatment seeking among African Americans. Though there are no foreseeable risks from participating in this study, if you feel that you need to talk to someone about your mental health, a debriefing statement will be provided where names and phone numbers of mental health agencies are listed for you to contact. If you have any questions or concerns about this study, please feel free to contact Dr. Janet Chang at (909) 537-5501.By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand, the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here ☐ Today's date: _____

APPENDIX C

DEBRIEFING STATEMENT

DEBRIEFING STATEMENT

The study in which you have just participated will explore the factors hat contribute to the reluctance of mental health seeking among African Americans. The goal of this study is to help mental health providers understand why African Americans are underutilizing mental health services, so that methods to increase utilization can be developed.

Your participation in this study and answers to the questionnaire will be held in confidence. You will not be affected in any way through your participation and responses to the study. If you have any questions or wish to know the results of the study, please call or leave a message for Natalie Majors or Dr. Janet Chang at the Department of Social Work, California State University, San Bernardino (909) 537-5501.

Below are two locations where you can go to talk with someone regarding your mental health, if you need to do so:

1. Dr. Chris Esteves
   Lifeway Church
   7477 Vineyard Ave
   Rancho Cucamonga, CA 91730
   (909) 948-5557

2. Mission City Community Network
   10200 Sepulveda Blvd. Ste. 300-B
   Mission Hills, CA 91345
   (818) 830-1008

Thank you for participating in this study. The researchers greatly appreciate the time and effort you have taken in completing this questionnaire.

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